DISCUSSION OF THE PAPER BY JOYCE C. LASHOF: "THE HEALTH CARE TEAM IN THE MILE SQUARE AREA, CHICAGO"*

IRIS R. SHANNON

Director of Community Nursing
Mile Square Health Center
Chicago, Ill.

As a member of the Mile Square Center team I have been amazed by the variety of services that have been offered to such a large number of patients in such a short period of time. We necessarily have had to cope with problems commensurate with this rapid growth. Many of these problems have been resolved; however, others have been more difficult and solutions are still being sought. For example:

1) It was not possible to anticipate fully the kinds of operational difficulties we have experienced. Neither the review of available demographic data and vital statistics, nor the experiences of other neighborhood health centers, nor the needs and programs identified by the community, nor the previous professional experiences of our staff prepared us to serve 10,000 patients that registered in less than 15 months. We accept the fact that the size of our patient load is a reflection of the acceptance and need for such a program in the Mile Square area. However, it has brought with it overwhelming problems of space (service area for patients as well as office space), staffing (professional and nonprofessional) and problems related to coping with large numbers of patients who have complex needs for medical care. Although the center represents the first opportunity for most of our patients to receive comprehensive medical care, many still use the facility for acute or crisis care. To break this community tradition will require a concerted educational effort combined with a demonstration of our intent to stay in the community and render such service.

2) Recruitment of professional personnel continues to be a problem. The location of the center in the heart of a Negro ghetto, the challenge

*Presented in a panel, Group Practice in Comprehensive Health Care Centers, as part of the 1968 Health Conference of The New York Academy of Medicine, *Group Practice: Problems and Perspectives,* held at the Academy, April 25 and 26, 1968.

of working with a poverty-stricken population inundated with multi-problem patients and families whose interrelated health, economic, social, and emotional ills respond slowly to therapy necessitates *elective* as well as *selective* processes in staffing. For some health workers who come into the ghetto the delivery of care is a concept which can be easily accepted intellectually; however, the emotional acceptance of working in such areas may not be known to the worker until he has been tested. It is my opinion that health workers coming into the project must become *involved* in the total care of the patient or family. A genuine interest in the patient is as therapeutic as any chemotherapy. Expression of this interest helps to treat the feelings of exhaustion, fear, pessimism, isolation, and defeat—all symptoms which social scientists have identified as frequently affecting the poor.

3) Another realization is that few professionals come to the center with enough experience and understanding of the patients they serve. We have discovered that to function effectively with our population it is necessary to understand the medical, sociological, psychological, and anthropological factors which influence the patient's or family's ability to utilize health services. We have therefore structured our in-service efforts in these directions. Physicians have discussed health problems frequently seen in our population; an urban anthropologist has reviewed the ghetto, life styles, and mechanisms for coping; a psychiatrist has reviewed crisis intervention and alcoholism; a community minister, the role of the church in the Negro community; and a pediatrician and community health nurses (through presentation of case studies) have reviewed malignant deprivation and its effect on growth, development, child-rearing practices, and family functioning. These sessions are held weekly and are attended for the most part by the professional staff. Dr. Lashoff mentioned the constant consultative procedure that the department of nursing maintains with personnel from social service and psychiatry; however, the nurses also have weekly meetings with representatives from these departments to review appropriate concepts applicable to the understanding of the problems being experienced by some families. Some nurses have gone beyond our in-service programs to enroll in local graduate programs in universities that offer courses in inner-city studies. At this time, the only known programs offering such educational opportunities are in schools of education; however, nurses who have completed such courses and are presently taking classes have found them

extremely appropriate and useful in expanding their understanding of the dynamics involved in living in the ghetto.

4) The blending of the professional and nonprofessional indigenous worker requires constant examination of attitudes and behavior by both categories of personnel. However, our efforts have resulted in many nonprofessionals feeling for the first time in their employment experience that they are important and are making a meaningful contribution in the delivery of care to patients. This has given many indigenous workers pride in their job and a determination to make the project successful. Others have had enough positive experiences and encouragement to explore, seeking other health opportunities in such areas as practical nursing.

We consider our first year of operation a successful demonstration of the effectiveness of a neighborhood health center. The staff recognizes that our efforts represent only a beginning and that a great deal more will be demanded of us if we are to meet the health needs of the population we serve. We look forward to the challenges ahead, for we believe that the health needs of our population can best be met by a neighborhood health center that offers comprehensive medical services that are family-oriented.